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9 UNITED STATES DISTRICT COURT  
10 SOUTHERN DISTRICT OF CALIFORNIA  
11

12 FRED A SUSSMAN,  
13 Plaintiff,

14 v.

15 ARMELIA SANI, M.D., SHILEY EYE  
16 CENTER, UCSD MEDICAL CENTER,  
REGENTS OF THE UNIVERSITY OF  
17 CALIFORNIA, HEALTH NET, INC.,  
HEALTH NET SENIORITY PLUS,  
18 LINDA BEACH, HAIDEE  
GUTIERREZ, and DOES 1 through 40,  
19 inclusive,

20 Defendants.  
21  
22

CASE NO. 08 CV 0392 H BLM

Honorable Marilyn L. Huff  
Action Removed: March 3, 2008

**NOTICE OF MOTION AND  
MOTION TO DISMISS  
PLAINTIFF'S COMPLAINT  
PURSUANT TO FEDERAL RULE  
OF CIVIL PROCEDURE 12(b)(1)  
AND 12(b)(6); MEMORANDUM OF  
POINTS AND AUTHORITIES IN  
SUPPORT THEREOF**

[Filed concurrently with Request for  
Judicial Notice]

DATE: April 7, 2008  
TIME: 10:30 a.m.  
CTRM: 13

23 TO PLAINTIFF AND HER ATTORNEYS OF RECORD:

24 PLEASE TAKE NOTICE that on April 7, 2008 at 10:30 a.m., or as soon  
25 thereafter as the parties may be heard in Courtroom 13 of the above-entitled court  
26 located at 880 Front Street, San Diego, California 92101, defendant Health Net of  
27 California, Inc. ("Health Net") will and hereby does move this court to dismiss the  
28 eighth, ninth and tenth causes of action alleged against Health Net in the state court

1 complaint of plaintiff Freda Sussman ("plaintiff") pursuant to Federal Rule of Civil  
 2 Procedure 12(b)(1) on the grounds that the Court does not have subject matter  
 3 jurisdiction over this case, and plaintiff has not stated a claim upon which relief may  
 4 be granted pursuant to Federal Rule of Civil Procedure 12(b)(6).

5 Briefly stated, plaintiff's claims, all based on alleged denial of Medicare  
 6 benefits, are subject to exclusive administrative review by the Health Care Financing  
 7 Administration (HCFA) as provided by the Medicare Act, and judicial review is  
 8 available only after the HCFA has rendered a final decision on the claim. Plaintiff  
 9 has not exhausted her administrative remedies afforded by the Medicare Act.  
 10 Plaintiff's failure to state a claim upon which relief may be granted is based upon the  
 11 Medicare Act, specifically the 2003 amendment to the Medicare Act known as the  
 12 Medicare Prescription Drug, Improvement, and Modernization Act of 2003  
 13 ("MMA"), which preempts all state law causes of action arising from claims by a  
 14 plan member concerning the requirements, limitations, and procedures for Medicare  
 15 services furnished, or paid for, by Medicare Advantage organizations through  
 16 Medicare Advantage plans, such as plaintiff alleges Health Net issued to her.

17 This motion will be based upon this notice of motion and motion, the  
 18 memorandum of points and authorities filed herewith, the Request for Judicial  
 19 Notice, the declaration of Marci Armin, all pleadings and papers on file herein, all  
 20 matters of which the court must or may take judicial notice, and upon such other and  
 21 further evidence and argument as the court deems just and proper.

22  
 23 DATED: March 10, 2008

LEWIS BRISBOIS BISGAARD & SMITH LLP

24  
 25 By s/Kristin P. Kyle de Bautista

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## MEMORANDUM OF POINTS AND AUTHORITIES

### I. INTRODUCTION

Plaintiff Freda Sussman (“plaintiff”) was a member of a Seniority Plus Medicare Advantage plan issued by Health Net of California, Inc. (“Health Net”). In her state court complaint, plaintiff attempts to allege three causes of action against Health Net arising out of her membership in “Seniority Plus,” (1) Bad Faith Insurance Tactics; (2) Fraud and Deceit; and (3) Unfair Business Practices. Plaintiff claims that she was denied recommended rehabilitation services and had to pay for them herself. Plaintiff further alleges that Health Net made marketing misrepresentations to her and other members of the public that they will receive adequate care, to induce them to enroll in Seniority Plus. Finally, plaintiff alleges unfair business practices against Health Net, by using incentives and disincentives to health care providers to discourage the rendering of necessary care to enrollees. (*Complaint*, ¶¶ 52-73.)

By this motion to dismiss, Health Net establishes that the bad faith, fraud and unfair business practices causes of action, which complain of Health Net’s denial of Medicare benefits to plaintiff, and the improper marketing of its Medicare Advantage product, are preempted and supplanted by exclusive administrative remedies, not exhausted by plaintiff, set forth in the Medicare Act, and specifically to the remedies provided by the 2003 amendment to the Medicare Act known as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”).

The Seniority Plus contract that sets forth plaintiff’s rights and obligations under her plan (“Evidence of Coverage” or “EOC”), contains comprehensive procedures for seeking medical care, and for making complaints about denial of, and quality of, medical benefits. In brief, plaintiff has the statutory and contractual right to appeal what are called “organization determinations,” that involve a denial of health care benefits she contends are covered. Both the Medicare Act and the

1 contract issued to Ms. Sussman contain a six-step process that culminates in the right  
2 to consideration by the United States District Court, not a state court – and not  
3 earlier.

4 Thus, all of plaintiff's claims for relief fall under both Health Net's contractual  
5 appeals and grievances procedures and the administrative process set forth in the  
6 Medicare Act and regulations promulgated pursuant thereto. Since plaintiff has  
7 never commenced – much less exhausted – these administrative remedies, a  
8 precondition to judicial review, the Court does not have subject matter jurisdiction  
9 over this action.

10 Additionally, plaintiff's claims against Health Net, all based on state law, are  
11 completely preempted by federal law, and therefore do not state claims for any  
12 available relief.

13 Accordingly, plaintiff's eighth, ninth and tenth causes of action against Health  
14 Net must be dismissed.

## 15 **II. PROCEDURAL BACKGROUND**

16 Plaintiff commenced this action in San Diego County Superior Court on  
17 November 13, 2007. Health Net removed the action to this District Court on March  
18 3, 2008, asserting that the action presents a federal question. Health Net now brings  
19 the instant motion asserting that plaintiff's state statutory and common law contract  
20 and tort claims that relate to her Medicare Advantage plan are preempted by the  
21 Medicare Act and that plaintiff must first exhaust the administrative remedies  
22 afforded by the Medicare Act before she is entitled to review of any administrative  
23 decision by the District Court.

## 24 **III. FACTUAL BACKGROUND**

25 According to the complaint, plaintiff was a participant in the Health Net  
26 "Seniority Plus" plan, a Medicare Supplement program administered by Health Net.  
27 (*Complaint*, ¶ 54.) On or about February 23, 2007, plaintiff suffered a stroke, and  
28 was admitted to the intensive care unit of Alvarado Hospital (*Complaint*, ¶¶ 19, 54.)

1 Plaintiff claims that after seven days at Alvarado Hospital, Health Net ordered her  
2 transferred to the University of California, San Diego ("UCSD") Medical Center  
3 even though she was still in an "unstable" condition. (*Complaint*, ¶ 54.) Just prior  
4 to the transfer, plaintiff asserts that two physicians, an internist, Dr. Ramenini, and a  
5 neurologist, Dr. Evens, recommended that she be placed in an acute rehabilitation  
6 facility. (*Complaint*, ¶ 55.) Despite the physician recommendations, plaintiff claims  
7 that the UCSD Medical Center determined that plaintiff was not eligible for  
8 rehabilitation therapy based on the opinion of one of the medical center's physical  
9 therapists. (*Complaint*, ¶ 56.) The physical therapist determined that plaintiff could  
10 not endure three hours of rehabilitation services a day, and recommended transfer to  
11 a nursing facility. (*Complaint*, ¶ 56.) Plaintiff claims that Health Net refused to  
12 authorize necessary rehabilitation services based upon the groundless opinion of a  
13 physical therapist in contradiction to the opinions of two qualified physicians, and  
14 that Health Net did so as part of a pattern and practice of refusing to pay for adequate  
15 care for its members in order to increase its profits. (*Complaint*, ¶¶ 58-59.) As a  
16 result, plaintiff was forced to incur or pay for rehabilitation services out-of-pocket to  
17 avoid placement in a nursing facility. (*Complaint*, ¶ 57, 61.) Plaintiff alleges that  
18 Health Net's conduct constitutes "bad faith insurance tactics."

19 Additionally, plaintiff alleges a cause of action against Health Net for fraud  
20 and deceit. Plaintiff asserts that Health Net engages in a practice of representing to  
21 members of the public that, by enrolling in the Seniority Plus plan, enrollees will  
22 receive thoroughly adequate care that is superior to that provided by Medicare.  
23 (*Complaint*, ¶ 65.) Plaintiff claims, however, that through the use of incentives and  
24 disincentives to providers, Health Net actually discourages the rendering of  
25 necessary care to its members. (*Complaint*, ¶ 65.)

26 Finally, plaintiff alleges that Health Net's use of combined incentives and  
27 disincentives to providers to discourage the rendering of necessary care in order to  
28 garner more profits constitutes an unfair business practice within the meaning of

1 California Business and Professions Code Section 17200 *et seq.* (*Complaint*, ¶¶ 70,  
2 72-73.)

### 3 **IV. ARGUMENT**

#### 4 **A. Authority for Motion**

5 It is fundamental that lack of subject matter jurisdiction, although never  
6 waived, may be challenged by motion to dismiss (Rule 12(b)(1), F.R. Civ. Proc.;  
7 Moore, Federal Practice, § 12.30[1]), and that a motion to dismiss for failure to state  
8 a claim for which relief may be granted is authorized by Rule 12(b)(6). (Moore,  
9 Federal Practice, § 12.34[1].) Although defendant has the burden of persuasion on  
10 Rule 12(b)(6) motions, the opposite is true of motions under Rule 12(b)(1)  
11 challenging subject matter jurisdiction: “Once challenged, the party asserting  
12 subject matter jurisdiction has the burden of showing its existence.” (Moore, §  
13 12.30[5].)

#### 14 **B. Overview of Complete Preemption Afforded by the Medicare Act**

##### 15 **1. The Medicare Act contains an enforcement mechanism to** 16 **address each of plaintiff’s claims**

17 The Medicare Act sets forth a detailed, and exclusive, administrative scheme  
18 for addressing an enrollee’s concerns about the provision for, or payment of, medical  
19 care under a Medicare Advantage (“MA”) plan. In 2003, the Medicare Act was  
20 amended by a law entitled the Medicare Prescription Drug, Improvement, and  
21 Modernization Act of 2003 (“MMA”) to provide:

22 The standards established under this part shall supersede any State law  
23 or regulation (other than State licensing laws or State laws relating to  
24 plan solvency) with respect to MA plans which are offered by MA  
25 organizations under this part.  
26 (42 U.S.C. § 1395w-26(b)(3).) The legislative history of this provision makes clear  
27 that this amendment means what it says: “[T]he [Medicare Advantage Program] is a  
28 federal program operated under Federal rules and that State laws, [sic] do not, and

1 should not apply, with the exception of state licensing laws or state laws related to  
 2 plan solvency.” (H. Conf. Rep. 108-391 at 557, as quoted in *First Medical Health*  
 3 *Plan, Inc. v. Vega-Ramos*, 479 F.3d 46,51 (1<sup>st</sup> Cir. 2007.)

4 The Code of Federal Regulations explains that the scope of Part 422  
 5 “establishes standards and sets forth the requirements, limitations, and procedures for  
 6 Medicare services furnished, or paid for, by Medicare Advantage organizations  
 7 through Medicare Advantage plans.” (42 C.F.R. Ch. IV, Subch B, Part 422,  
 8 Medicare Advantage Program, 42 C.F.R. § 422.1.) Under these standards, when a  
 9 member is unhappy about the denial of benefits, she first appeals to the plan, then to  
 10 an administrative law judge. Either party dissatisfied with the ruling of the  
 11 administrative law judge can appeal to the Secretary of Health and Human Services.  
 12 If either party is dissatisfied with that ruling, he, she or it can seek judicial review in  
 13 the United States District Court. (42 U.S.C. §§ 405(g); 1395w-22(g)(5); 42 C.F.R.  
 14 Part 422, Subpart M. § 422.560, et seq.)

15 Additional standards regulate the remaining matters at issue in plaintiff’s  
 16 complaint. Marketing materials and election forms used by MA plans are regulated  
 17 by 42 C.F.R. § 422.80. “Marketing materials” are defined as including “any  
 18 informational materials targeted to Medicare beneficiaries” which promote the  
 19 Medicare Advantage plan, inform Medicare beneficiaries about enrollment, explain  
 20 the benefits of enrollment, and explain how Medicare services are covered under the  
 21 Medicare Advantage plan. (42 C.F.R. § 422.80(b)(1)-(4).) If an enrollee believes  
 22 that a Medicare Advantage plan is marketing its product in violation of these  
 23 regulations, he or she can file a grievance and participate in a multi-step grievance  
 24 procedure with CMS. (42. C.F.R. § 422.564.)

25 Thus, the Medicare Act expressly and completely preempts plaintiff’s causes  
 26 of action against Health Net. Her complaints about benefits must be addressed  
 27 through the administrative process described at 42 U.S.C. § 1395w-22(g) and her  
 28 complaints about marketing representations must be addressed through the

1 administrative process described at 42 C.F.R. § 422.564.

2 **2. The enforcement mechanisms afforded by the Medicare Act**  
 3 **mean that plaintiff's claims are completely preempted**

4 Removal is appropriate, and federal jurisdiction exists, under the "complete  
 5 preemption" doctrine where a federal statute (1) expressly preempts state law  
 6 standards; and (2) provides exclusive federal remedies. (*Beneficial National Bank v.*  
 7 *Anderson*, 539 U.S. 1, 123 S. Ct. 2058.) As discussed above, both of these  
 8 requirements are met here; as set forth at 42 U.S.C. § 1395w-26(b)(3), the Medicare  
 9 Act and its regulations expressly supersede any "State law or regulation" with  
 10 respect to MA plans; and exclusive federal remedies are provided for plaintiff's  
 11 complaints.

12 **C. Plaintiff's Claimed Entitlement To Benefits And "Bad Faith**  
 13 **Insurance Tactics" Allegations Fall Squarely Under The Medicare**  
 14 **Act And The MMA**

15 In her complaint, plaintiff has combined both her claim of entitlement to  
 16 benefits and allegations of bad faith conduct into one cause of action entitled "bad  
 17 faith insurance tactics." Plaintiff alleges that Health Net failed to approve and pay  
 18 for rehabilitation services – clearly health care services - and that Health Net did so  
 19 in bad faith. These claims are preempted, as discussed next below.

20 **1. Plaintiff's claim of entitlement to benefits is preempted.**

21 Because plaintiff's benefit claims "arise under" Medicare, her cause of action  
 22 for bad faith failure to pay for services is barred by the exclusive review provisions  
 23 of the Medicare Act. In *Heckler v. Ringer*, 466 U.S. 602 [104 S.Ct. 2013, 80  
 24 L.Ed.2d 622] (1984), the United States Supreme Court held that a claim arises under  
 25 Medicare if (1) both the standing and the substantive basis for the presentation of the  
 26 claim is the Medicare Act (*Id.* at 615), or (2) the claim is "inextricably intertwined"  
 27 with a claim for Medicare benefits. (*Id.* at 614.) A claim that is "wholly collateral"  
 28 to a claim for benefits under the Medicare Act is not subject to the exclusive review

1 provisions of the Act.

2 The “arising under” language has been interpreted to mean that claims which  
3 are, at bottom, claims for reimbursements of benefits are “inextricably intertwined”  
4 with a claim for benefits and, therefore, arise under the Medicare Act. (*Ardary v.*  
5 *Aetna Health Plans of Calif., Inc.*, 98 F.3d 496, 500 (9<sup>th</sup> Cir. 1996).) In *Ardary*, the  
6 Court of Appeal held that an action for compensatory and punitive damages brought  
7 by the heirs of a deceased Medicare beneficiary for a private Medicare provider’s  
8 failure to authorize an airlift to a larger hospital resulting in the beneficiary’s death  
9 was not preempted by the Medicare Act. The Court found that the claims were not,  
10 at bottom, seeking to recover benefits as a beneficiary’s death could not be remedied  
11 by the retroactive authorization or payment of the airlift transfer. (*Id.* at 500.)

12 However, in *Hooker v. United States Department of Health and Human*  
13 *Services*, 858 F.2d 525 (9<sup>th</sup> Cir. 1988), the Ninth Circuit rejected plaintiffs’ state law  
14 claims arising out of the Social Security Administration’s allegedly wrongful  
15 termination of disability benefits. There, Laurence Hooker committed suicide after  
16 he was denied further disability benefits. Among other things, his heirs sued two  
17 state employees for negligence. The district court dismissed the action, holding that  
18 42 U.S.C. Section 405 barred plaintiffs’ state law claim for negligence, since it was  
19 “merely a disguised dispute with the Secretary.” (*Id.* at 529.) The Ninth Circuit  
20 affirmed, holding that claims for damages arising out of the Secretary’s acts “arise  
21 under” the Medicare Act. (*Id.*) The Court specifically cited to the six-step  
22 administrative process that controls this dispute. (*See also, Jenkins v. Social*  
23 *Security Administration*, 42 Fed. Appx. 995 (9<sup>th</sup> Cir. 2002) [plaintiff could not  
24 circumvent exhaustion requirement of 42 U.S.C. § 405(h) by characterizing his  
25 action as one for civil rights violations].)

26 Here, plaintiff explicitly seeks to recover approximately \$51,000 in costs for  
27 rehabilitation services she claims to have incurred as a result of Health Net’s denial  
28 of her request for authorization. (*Complaint*, ¶¶ 57 and 61.) In this action, plaintiff’s

1 out-of-pocket expenses may be remedied by the retroactive payment of the disputed  
 2 benefits. Because plaintiff challenges Health Net's decision not to provide her with  
 3 rehabilitation therapy, and seeks damages relating to the denial of such benefits, her  
 4 sole remedy is that set forth in the Medicare Act. Plaintiff's claims are "inextricably  
 5 intertwined" with a claim for Medicare benefits and, therefore, arise under the  
 6 Medicare Act.

## 7 **2. Plaintiff's "bad faith" claim is preempted.**

8 To the extent this claim is for "bad faith" or breach of the implied covenant,  
 9 instead of for breach of contract, it, too, is preempted. While Health Net is a health  
 10 care service plan and not an insurer, analogizing to insurance law demonstrates that  
 11 this cause of action must fail, as a matter of law. It has long been established that a  
 12 "bad faith" cause of action is "on the contract." (*See, e.g., 20th Century Ins. Co. v.*  
 13 *Superior Court*, 90 Cal.App.4th 1247, 1280 (2001); *Prieto v. State Farm Fire &*  
 14 *Casualty Co.*, 225 Cal.App.3d 1188, 1193 (1990).) This is because an insurer can be  
 15 liable for breach of the implied covenant of good faith and fair dealing only if it  
 16 unreasonably withholds benefits due under the policy. (*Waller v. Truck Ins.*  
 17 *Exchange, Inc.*, 11 Cal.4th 1, 35 (1995); *Love v. Fire Ins. Exchange*, 221 Cal.App.  
 18 3d 1136, 1151 (1990).) If no benefits are due under the policy, a bad faith claim is  
 19 barred as a matter of law. (*Brodkin v. State Farm Fire & Casualty Co.*, 217  
 20 Cal.App.3d 210, 218 (1989); *Ray v. Farmers Ins. Exchange*, 200 Cal.App.3d 1411,  
 21 1418, fn. 4 (1988).)

22 Thus, a necessary predicate to plaintiff's "bad faith" cause of action is a  
 23 determination by the Secretary that there was a breach of contract; i.e., that plaintiff  
 24 is entitled to rehabilitation services benefits that she did not receive. Since only the  
 25 Secretary can make that determination, this cause of action is not yet ripe.

## 26 **D. Plaintiff's Cause Of Action For Fraud And Deceit Is Preempted By** 27 **The Medicare Act**

28 Plaintiff alleges in her fraud and deceit cause of action that Health Net

1 engages in a practice of representing to members of the public that, by enrolling in  
2 the Seniority Plus plan, enrollees will receive thoroughly adequate care that is  
3 superior to that provided by Medicare. (*Complaint*, ¶ 65.) Plaintiff claims, however,  
4 that Health Net, through the use of incentives and disincentives to health care  
5 providers, actually discourages the rendering of necessary care to its members.  
6 (*Complaint*, ¶ 65.) As a result, plaintiff states that she relied on Health Net's  
7 marketing misrepresentations, enrolled in the health plan and received substandard  
8 care (*Complaint*, ¶ 68.)

9 The MMA regulations squarely preempt this cause of action. Section 422.80  
10 of the Code of Federal Regulations regulates marketing materials, including any  
11 informational materials targeted to Medicare beneficiaries which promote the  
12 Medicare Advantage plan, inform Medicare beneficiaries about enrollment, explain  
13 the benefits of enrollment, or explain how Medicare services are covered under the  
14 Medicare Advantage plan, and provide an exclusive remedy for complaints arising  
15 out of that marketing material. (42 C.F.R. § 422.80(b)(1)-(4).)

16 In *Dial v. Healthspring of Ala., Inc.*, 501 F.Supp.2d 1348 (S.D. Ala. 2007) [on  
17 appeal to the 11<sup>th</sup> Circuit], plaintiffs claimed that agents of a Medicare Advantage  
18 plan fraudulently induced them to join the plan by misrepresenting plan benefits.  
19 They sued the plan for breach of contract, fraud, negligence and other torts. The  
20 plan removed the action, and plaintiffs moved to remand. Plaintiffs argued that they  
21 were seeking relief under state law only, and the preemption provision applies only  
22 to preclude a state's attempt to establish standards relating to or regulating Medicare  
23 Advantage plans. They also argued that their claims were not related to marketing,  
24 enrollment, benefit and coverage, and grievance procedures. The plan argued that  
25 the standards relating to the marketing of the plan and benefits disputes fell solely  
26 under federal law, so removal was proper. The district court found that:

27 [P]laintiffs' causes of action based upon defendants' meeting with the  
28 plaintiffs, soliciting their enrollment, and making representations as to

1 the quality and scope of benefits and coverage, and as to plaintiffs'  
 2 ability to continue treatment with their doctors and hospitals, fall within  
 3 areas which Congress intended to regulate through the MMA, and thus  
 4 are preempted by federal law.

5 (*Id.* at 1359.)

6 *Dial* relied, in part, on *First Medical Health Plan, Inc. v. Vega-Ramos, supra*,  
 7 which stated in dictum, "Congress' purpose in enacting § 1395w-26(b)(3) was to  
 8 protect the purely federal nature of Medicare Advantage plans operating under  
 9 Medicare...." (*Id.* at 51-52.)

10 Two cases from the Northern District of California have implicitly agreed that  
 11 the MMA affords complete preemption of plaintiff's fraud claim. In *Clay v.*  
 12 *Permanente Medical Group, Inc.*, 2007 WL 4374273 (N.D. Cal. 2007), plaintiff  
 13 alleged nine causes of action against Kaiser related to the alleged mishandling of a  
 14 kidney transplant. Kaiser removed the case, alleging jurisdiction pursuant to the  
 15 Medicare Act, and moved to compel arbitration. The court granted the motion to  
 16 compel arbitration, holding that the evidence of coverage was considered "marketing  
 17 materials," as that term is defined in 42 C.F.R. Section 422.80(b), and CMS's  
 18 approval of the Evidence of Coverage superseded any state law or regulation with  
 19 respect to Medicare Advantage plans. (*See also, Drissi v. Kaiser Foundation*  
 20 *Hospitals, Inc.*, 2008 WL 54382 (N.D. Cal. 2007) [granting motion to compel  
 21 arbitration].)

22 **E. Plaintiff's Cause Of Action For Unfair Business Practices Is**  
 23 **Preempted By The Medicare Act**

24 Plaintiff's unfair business practices cause of action fails for the same reason as  
 25 her fraud and deceit claim. Plaintiff alleges that Health Net's misleading marketing  
 26 and its use of combined incentives and disincentives to providers to discourage the  
 27 rendering of necessary care in order to garner more profits constitutes an unfair  
 28 business practice within the meaning of California Business and Professions Code

1 Section 17200 *et seq.* (*Complaint*, ¶¶ 71-73.) Specifically, plaintiff avers that  
 2 Health Net discouraged the use of physical therapy for good candidates such as the  
 3 plaintiff and rather attempted to send her to a nursing home as a purportedly less  
 4 expensive alternative. (*Complaint*, ¶ 72.) These allegations concern both the alleged  
 5 wrongful denial of benefits to plaintiff, and the purported improper marketing of  
 6 Health Net's Medicare Advantage product to the public at large. As discussed  
 7 above, such claims are preempted by the Medicare Act and the MMA and, therefore,  
 8 plaintiff's unfair business practices claim is also subject to preemption.

9 **F. Before Plaintiff's Claims May Be Considered By This Federal**  
 10 **Court, She Must First Exhaust The Administrative Remedies**  
 11 **Afforded By Contract And Under The Medicare Act.**

12 Federal Rule of Civil Procedure 12(b)(1) provides that a motion to dismiss  
 13 will lie where the court "lack[s] jurisdiction over the subject matter." Thus, in  
 14 *Heckler v. Ringer*, the United States Supreme Court held that a claim which 'arises  
 15 under' the Medicare Act must first be brought before the Secretary through a  
 16 multilevel administrative review process. (*Id.* at 605.) This administrative review  
 17 process (which is also expressly set forth in the contract between plaintiff and Health  
 18 Net) provides the exclusive remedy for such claims. *Judicial* review of such claims  
 19 is available only after the claimant has pressed the claim through every level of the  
 20 administrative review process to a "final" decision by the Secretary and even then  
 21 such review may only be obtained in *federal* court. (*Id.* at 605-606; *see also*  
 22 42.U.S.C. § 405(g).) Here, plaintiff has not participated in the administrative review  
 23 process and has not obtained a "final decision" from which she may seek judicial  
 24 review in this forum. In short, plaintiff has not exhausted her administrative  
 25 remedies and this Court does not have subject matter jurisdiction over the lawsuit.

26 **G. Plaintiff's Contract With Health Net Sets Forth The Comprehensive**  
 27 **Administrative Review Scheme Mandated By The Medicare Act**

28 The Evidence of Coverage sets forth the comprehensive scheme for dealing

1 with member concerns. Section 11 entitled "Information on how to make a  
 2 complaint about Part C medical services and benefits," provides nine pages of  
 3 information about Health Net's complaint procedures. With respect to a complaint  
 4 about what benefits or service Health Net will provide or what benefits or service  
 5 Health Net will cover, the EOC describes six steps that a member can take if  
 6 dissatisfied with care or payment from Seniority Plus. In brief, Health Net makes an  
 7 "initial decision," also called an "organization determination," about the medical  
 8 care or payment for medical care.

9 An "organization determination" is defined in the MA [Medicare Advantage]  
 10 regulations as follows:

11 (b) ... An organization determination is any determination made by  
 12 an MA organization with respect to any of the following:

13 ...

14 (2) Payment for any other health services furnished by a  
 15 provider other than the MA organization that the enrollee  
 16 believes--

17 (a) Are covered under Medicare; or

18 (b) If not covered under Medicare, should have been furnished,  
 19 arranged for, or reimbursed by the MA organization.

20 (3) The MA organization's refusal to provide or pay for  
 21 services, in whole or in part, including the type or level of  
 22 services, that the enrollee believes should be furnished or  
 23 arranged for by the MA organization.

24 ...

25 (5) Failure of the MA organization to approve, furnish, arrange for,  
 26 or provide payment for health care services in a timely manner, or  
 27 to provide the enrollee with timely notice of an adverse  
 28 determination, such that a delay would adversely affect the health

of the enrollee.”

(42 CFR § 422.566.)

If the member is unhappy, she can appeal or request reconsideration of the decision. If the appeal or reconsideration request is denied in whole or in part, Health Net is required to send the request to an independent review organization that has a contract with the federal government. If the member is unhappy with the outcome of the review, she can ask for an Administrative Law Judge to consider the case and make a decision. If either party is unhappy with the outcome of that decision, she or it may seek review before the Medicare Appeals Council. If either party is unhappy with that review, she or it can seek review of that determination before this Court. (*Evidence of Coverage*, pp. 77-85, Exh. “A” to the Request for Judicial Notice “RJN”)<sup>1/</sup> This is consistent with the statutory Medicare scheme, which provides that alleged refusal or failure to arrange for health services constitutes an “organization determination” which is subject to the congressionally mandated administrative procedure set forth at 42 U.S.C. Section 1395w-22(g). Organization determinations are appealable to the Secretary of Health and Human Services. (42 U.S.C. § 1395w-22(g)(5).) If an enrollee is dissatisfied with the Secretary’s decision, he or she can seek judicial review **in the district court**. (42 U.S.C. §§ 405(g), 1394w-22(g)(5).) Thus, a final decision by the Secretary on a claim “arising under” Medicare may be reviewed by this Court.

**H. This Action Should Be Dismissed As Premature Since Plaintiff Has Not Exhausted Her Administrative Remedies**

In *Clorox v. U.S. Dist. Ct. for N.D. of California*, 779 F.2d 517, 522 (9<sup>th</sup> Cir. 1985), the court stated:

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<sup>1/</sup> As plaintiff bases her lawsuit on the Seniority Plus plan, but did not attach it as an exhibit to her complaint, Health Net may attach the contract as an exhibit and the Court may consider the contract in this motion. (*See Fecht v. Price Co.*, 70 F.3d 1078, 1080, fn. 1 (9<sup>th</sup> Cir. 1995) [quoting *Branch v. Tunnell*, 14 F.3d 449 (9<sup>th</sup> Cir. 1994)]).

Under the derivative jurisdiction doctrine, if the state court lacked subject matter jurisdiction over Stower's negligent management claim, the district court also lacked jurisdiction over the claim upon removal. *See, e.g., Dyer v. Greif Brothers, Inc.*, 766 F.2d 398, 399-400 (9<sup>th</sup> Cir. 1985); *Schroeder v. Trans World Airlines*, 702 F.2d 189 (9<sup>th</sup> Cir. 1983); *Valenzuela v. Kraft*, 739 F.2d 434 (9<sup>th</sup> Cir. 1984). Once the district court discovers that the state court had no jurisdiction over a claim, rather than engage in a fruitless remand to a state court that lacks independent subject matter jurisdiction, it should dismiss the claim without prejudice to a motion for leave to amend the complaint to add the dismissed claim. *See Franchise Tax Board v. Construction Laborers' Vacation Trust*, 463 U.S. 1, 24 n. 27, 77 L.Ed.2d 420, 103 S.Ct. 2842 (1983); *Schroeder*, 702 F.2d at 192; *see also Freeman v. Bee Machine Co.*, 319 U.S. 448, 451, 87 L.Ed. 1509, 63 S.Ct. 1146 (1943) (jurisdiction by removal does not deprive the federal court of power to permit amendments to the complaint adding exclusively federal claims.)

Although *Clorox* arose under the prior "derivative jurisdiction doctrine," overruled by the enactment of 28 U.S.C. Section 1441(e), the concept remains the same where, as here, the state court from which the case was removed lacks subject matter jurisdiction over the dispute. It would be fruitless to return the case to the state court. Instead, if the Court decides it lacks jurisdiction, because plaintiff has not exhausted her administrative remedies, the case should be **dismissed** in favor of the mandatory administrative process, not remanded.

The Court faced a similar "failure to exhaust administrative remedies" issue on a copyright case removed from state court. (*Dielsi v. Falk*, 916 F.Supp. 985 (C.D. Cal. 1996).) While federal courts have exclusive jurisdiction over copyright claims, federal copyright law preempted two of the plaintiff's claims as a result of plaintiff's failure to comply with federal regulations prior to filing suit. (28 U.S.C. § 1338.) A

1 prerequisite to the filing of a federal copyright claim, a litigant must first have  
 2 completed an application for copyright registration. Plaintiff's failure to plead that  
 3 he applied for copyright registration deprived the Court of subject matter  
 4 jurisdiction. (*Dielsi, supra*, 916 F.Supp. at pp. 993-994.) The Court dismissed the  
 5 claims rather than remanding them to state court, stating:

6 This case presents an intriguing jurisdictional puzzle which no reported  
 7 federal copyright case has squarely addressed. Because federal  
 8 copyright law completely preempts plaintiff's Fifth and Sixth Causes of  
 9 Action, this case was properly removed to federal court. However, after  
 10 exercising its removal jurisdiction, the Court concludes that it must  
 11 dismiss the claim for lack of subject matter jurisdiction under 17 U.S.C.  
 12 § 411(a). This appears paradoxical, but it is the only result that makes  
 13 sense. If the Court simply remanded the copyright claim to state court  
 14 for lack of subject matter jurisdiction, this order would be meaningless  
 15 because under 28 U.S.C. § 1338, federal courts have exclusive  
 16 jurisdiction over copyright claims.

17 (*Id.* at 994.)

18 The instant case presents a paradox similar to the one faced by the *Dielsi*  
 19 Court. Federal courts have exclusive jurisdiction over issues relating to Medicare  
 20 coverage. (42 U.S.C § 405(g).) But, the administrative process must first be  
 21 exhausted. (42 U.S.C § 1395w-22(g)(5).) Because plaintiff has not exhausted the  
 22 administrative process, just as the plaintiff in *Dielsi* did not apply for copyright  
 23 registration, this court lacks subject matter jurisdiction to grant plaintiff any of the  
 24 relief she seeks. As the Court did in *Dielsi*, this Court should dismiss this matter and  
 25 not remand it to state court, which clearly does not have subject matter jurisdiction.  
 26 A remand would be fruitless and meaningless.

27 ///

28 ///

1 **V. CONCLUSION**

2 For the foregoing reasons, defendant Health Net respectfully requests its  
3 motion to dismiss be granted on the grounds stated herein.

4 DATED: March 10, 2008

LEWIS BRISBOIS BISGAARD & SMITH  
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**FEDERAL COURT PROOF OF SERVICE**

Freda Sussman v. Health Net of California, Inc. - File No. 25713-217

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

At the time of service, I was over 18 years of age and not a party to the action. My business address is 221 North Figueroa Street, Suite 1200, Los Angeles, California 90012. I am employed in the office of a member of the bar of this Court at whose direction the service was made.

On March 10, 2008, I served the following document(s): **NOTICE OF MOTION AND MOTION TO DISMISS PLAINTIFF'S COMPLAINT PURSUANT TO FEDERAL RULE OF CIVIL PROCEDURE 12(b)(1) AND 12(b)(6); MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF.**

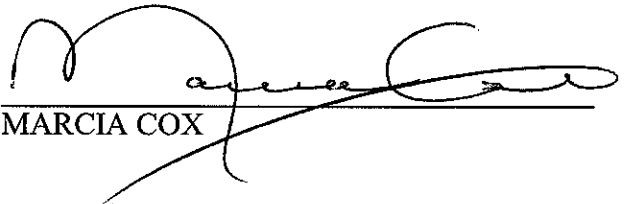
I served the documents on the following persons at the following addresses (including fax numbers and e-mail addresses, if applicable): **SEE ATTACHED SERVICE LIST.**

The documents were served by the following means:

☒ (BY U.S. MAIL) I enclosed the documents in a sealed envelope or package addressed to the persons at the addresses listed above and I deposited the sealed envelope or package with the U.S. Postal Service, with the postage fully prepaid.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on March 10, 2008, at Los Angeles, California.

  
MARCIA COX

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